STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN5502	A. BUILDING: **01 - MAIN BUILDING 01** B. WING _____	R **09/01/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMSVILLE HEALTHCARE AND REHABILITATION C	**409 PARK AVENUE** **ADAMSVILLE, TN 38310**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	Initial Comments A Life Safety follow-up desk review was conducted on 09/1/2021 for the previous deficiencies cited on 8/2/2021. The deficiencies have been corrected, and no new non compliance was found. The facility is in compliance with all regulations surveyed.	{N 000}		